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Recovered eating disorder therapists using their experiential knowledge in therapy: A qualitative examination of the therapists' and the patients' view

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ABSTRACT

In the eating disorder (ED) field there is a lack of guidelines regarding the utilization of recovered therapists and the experiential knowledge they can bring to therapy. In this study, a qualitative design was used to examine recovered eating disorder therapists using their experiential knowledge and how this influences therapy and the patients they treat. Respectively, 205 patients (response rate 57%), and 26 recovered therapists (response rate 75%) completed a questionnaire about advantages and disadvantages of the utilization of experiential knowledge in therapy. Results showed that using experiential knowledge can have several advantages and disadvantages in therapy. Therapists can use this knowledge as a therapeutic intervention with specific goals, such as providing the patient with insight into the recovery process, establishing a working relationship, and enhancing hope for recovery. To be effective, self-disclosure and experiential knowledge need to be shared thoughtfully, and should not include specific details about ED symptoms. Other factors noted that enhanced the benefits of experiential knowledge included therapist self-insight and self-care, adequate training and guidance, and a safe work environment. Patients stated that being treated by a recovered therapist had a positive effect on their recovery process. It is advised to establish guidelines in the ED field about working with recovered therapists and the experiential knowledge they might use in therapy. Further research is needed on the process of when, how, and which experiential knowledge is shared by recovered therapists in therapy, and the effects of these interventions on patients and their treatment outcomes.

Introduction

Therapists who have had a personal history of a mental disorder have gained experiential knowledge about the disorder and the treatment and recovery process inherent to their illness. Experiential knowledge can be described as “information and wisdom gained from lived experience” (Berg, 2008). It

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relates to the knowledge and understanding of things and events through direct engagement. This lived experience incorporates the actual experience itself, along with the meanings attributed to this experience by the person experiencing it (Berg, 2008). It is expected that the development of experiential knowledge can positively influence the recovery process of patients (Netten, 2003; Wilrycx, 2014). Sharing this experience with patients who have the same disorder or illness provides opportunities for reflection on how the personal process of recovery is taking place (Wilrycx, 2014). The benefits of experiential involvement from peer supporters or recovered therapists can be therapeutic in itself (Netten, 2003; Wilrycx, 2014). Renown psychologists have claimed the importance of experiential knowledge or wisdom developed from their own “woundedness” or personal experiences with mental illness (Jung, 1951; Nouwen, 1979; Zerubavel & Wright, 2012).

Within the last two decades, there has been a worldwide and rapid growth of a recovery oriented movement within the field of mental diseases (Advisory Council Australian Health Ministers, 2012; Davidson et al., 1999; Hogan, 2003; Roberts & Wolfson, 2003; Solomon, 2004). This movement consists of three major developments, namely; (a) a shift in interest about the perspective on recovery from treatment providers to consumers (patients), (b) a fast growing utilization of peer supporters (recovered or recovering patients) within treatment centers, and (c) a paradigm change from a medical model of mental sickness to a bio-psychosocial-spiritual model of personal development. These developments are in large part based on experiential knowledge. Peer supporters use their experiential knowledge in several ways to support the recovery process of patients, by utilizing self-disclosure and sharing aspects of their own recovery process with patients, as well as by teaching healthcare professionals about their recovery process.

It is remarkable that experiential knowledge and peer support has grown so large within several mental health fields, despite the lack of evidence regarding its influences on treatment. It has led to many guidelines on how to incorporate this knowledge within treatment. In the Netherlands, for instance, several guidelines on working with peer supporters have been formulated (Boertien & Bakel, 2012; Karbouniaris & van de Watering, 2012). This is also the case for the United States, Canada, the UK and Australia (Advisory Council Australian Health Ministers, 2012; Basset, Faulkner, Repper, & Stamou, 2010; Repper et al., 2013; SAMHSA, 2011; Sunderland et al., 2013). A significant oversight within the recovery movement is the fact that a substantial number of professional therapists also have personal experiential knowledge from their own recovery process. However, a sharp distinction is made between peer supporters and clinical workers or professional therapists. To our knowledge, no guidelines have thus far been published for utilizing recovered therapists. Moreover, within the ED field,

there is an ongoing debate whether recovered therapists should treat patients with ED, and whether and when it is appropriate to self-disclose their ED history in treatment (Costin & Johnson, 2002; Johnston, Smethurst, & Gowers, 2005).

Addictions and EDs are two fields in which a substantial number of practicing therapists are recovered, or are still in recovery. It is estimated that in the addiction field between 37% and 57% of the treatment providers are themselves in recovery or recovered (Knudsen, Ducharme, & Roman, 2006; McNulty & Oser, 2007). Within the ED field, the range of therapists who have a personal history of an ED is between 24% and 47% (Barbarich, 2002; Bloomgarden, Gerstein, & Moss, 2003; Costin & Johnson, 2002; Johnston et al., 2005; Warren, Schafer, Crowley, & Olivardia, 2013).

Both advantages and disadvantages have been found in research regarding therapists having a personal history of an ED. Johnston et al. (2005) did a study among treatment providers with and without a history of an ED, patients in recovery or recovered, and their care-givers. They found several advantages, such as increased therapist empathy and expertise, the therapist as a role model, and the emergence of a more equal treatment relationship. In a study among 139 treatment providers with a personal history of an eating disorder, Warren et al. (2013) found that increased therapist empathy, related to relational understanding of the therapist, was the most emerging positive theme. Other positive themes included: greater therapist understanding or knowledge of the disorder and/or treatment process; retaining a positive outlook on patients or the treatment outcome; and instilling positive emotions within patients, such as feelings of hope, safety and being understood (Warren et al., 2013). Program directors Costin and Johnson (2002) reflected on working with recovered clinicians. Their experience was consistent with prior research, emphasizing the clinical advantages of utilizing recovered ED professionals in the treatment. Patient benefits noted included increased feelings of hope, motivation, trust, being understood, and diminished levels of shame. Costin and Johnson (2002) also described advantages conferred to the recovered therapist, such as increased empathy, challenging narcissism and grandiosity, and avoiding getting stuck in psychodynamic work.

Also several disadvantages of recovered therapists practicing in the ED field have been noted (Costin & Johnson, 2002; Johnston et al., 2005; Warren et al., 2013). For example, countertransference processes, the therapist over-identifying with the patient, being too involved with the patient, becoming emotionally triggered, lacking objectivity in therapy, the risk of relapse for the therapist, and remaining negative temperamental traits (e.g., being critical, impatient, judgmental, overly driven) can be undesirable aspects of having a personal history of an ED (Costin & Johnson, 2002; Johnston et al., 2005; Warren et al., 2013).

Despite lacking guidelines, there are several treatment facilities in the United States, such as Monte Nido and The Emily Program, which work with recovered therapists and claim that this is a program strength. At Monte Nido, approximately 75% of the staff is recovered from an eating disorder, and when only taking therapists, dietitians, and support counselors into account, this figure rises to approximately 85% (Costin & Johnson, 2002).

However, little is known about the process of recovered therapists using experiential knowledge in therapy, for instance, by giving patients advice from this knowledge or self-disclosing things about their ED past. Bloomgarden et al. (2003) disseminated a survey to all the staff within their treatment facility, asking about eating disorder histories as well as their observations about how this issue is dealt with during treatment. They found that 67% of the therapists in their survey used self-disclosure in their treatment approach, and that all recovered therapists used it in their therapy in some way (Bloomgarden et al., 2003).

According to another study among treatment providers, both therapists with and without a personal history of an ED, are more often against obliged self-disclosure of the ED (46%) than for (32%, Johnston et al., 2005). However, from the patients who received such a disclosure in therapy from a treatment provider, 72% evaluated this as positive. As Warren and colleagues (2013) state, future research should more systematically examine how frequently treatment providers with a personal history disclose this information to patients, how these decisions are made, and how they use these disclosures in treatment.

On one hand, it is said that self-disclosing information about having had an ED can lead to loss of therapeutic boundaries in treatment or complicated countertransference issues (Costin & Johnson, 2002; Johnston et al., 2005). On the other hand, when therapists are not able to express themselves and talk openly about things that affect themselves, it is questionable whether the therapist can be authentic in therapy. Also, when they have valuable experiential knowledge, which may help patients in their recovery process, it may be considered unethical, not to use this knowledge.

In The Netherlands, a specialized ED treatment center (Human Concern Foundation) is developed which works primarily with recovered therapists and considers this a program strength (Netten, 2003). Therapists are actively hired based on being recovered, and they are trained on how to use their experiential knowledge in treatment before entering their job as a therapist (Netten, 2003). Since the start in 1998 and its inception as a foundation in 2003, Human Concern has become one of the largest specialized ED facilities in the Netherlands. These recovered therapists are the principal therapists providing treatment in collaboration with a multidisciplinary team consisting of dietitians, psychiatrists, psychotherapists, and family therapists.

This is the first study that qualitatively examined the view of both trained recovered therapists and their patients on the use of experiential knowledge in therapy. The following themes were examined:

- (1) Whether and how experiential knowledge of the therapist influences therapy, from both the patient and therapist perspectives;
- (2) How and why recovered therapists use or disclose experiential knowledge;
- (3) How to skillfully use experiential knowledge in therapy.

Methods

Participants

Participants were both therapists recovered from an ED and ED patients from Human Concern. Questions for the patients were presented within a broader patient satisfaction survey. Of the 357 patients who received an invitation for this study 205 patients completed the questionnaire (response rate 57%).

Of all recovered therapists ($N = 32$) who worked at Human Concern during the study and who received a questionnaire by mail, 24 therapists filled in the questionnaire (response rate 75%).

All patients and therapists who completed the questionnaire did this voluntarily and were informed about the anonymity and the purpose of the study.

Instruments

This study examined the view of ED patients and recovered ED therapists, using a qualitative approach. A questionnaire (vs. interview) format was chosen to include a larger number of participants. The questionnaire for the patients was designed by the first two authors and a recovered professional who did not further participate in the research. The questionnaire contained questions with both closed answer options (i.e., Likert scale or yes/no answers) and open-ended questions, regarding patient satisfaction, as well as the therapist applying experiential knowledge in therapy.

The questionnaire for the recovered therapists was designed by the three authors. The questionnaire contained questions with closed answer options (i.e., Likert scale, or yes/no answers) and open-ended questions regarding demographics, experiential knowledge, self-disclosure, self-care, and questions about the work environment.

Analysis

Questions with categorical answers were analyzed by calculating averages and percentages. For questions with open answers, a systematic inductive

approach was used to evaluate their meaning and summarize them in themes (Bruce, 2007; Thomas, 2006). The systematic inductive approach is a qualitative procedure that consists of a couple of steps. First, the texts are carefully read. Then, the underlying meanings of the answers are deduced, and any recurring themes that arise are reported and labeled. To prevent data from being distorted, this process was carried out by the first author, after which the third author examined the themes and compared them with the raw answers. Differences in labeling were discussed until consensus was reached concerning the meaning of the data and a final set of themes was reached (Ryan & Bernard, 2003). When participants answered multiple qualitative themes within one question, all themes were scored as applicable. Only themes which emerged four or more times were reported.

Results

Demographics

Demographics of the participants were divided by patients (Table 1), and recovered therapists (Table 2). Regarding the patients, 98% of them were female with an average age of 27.25 years ($SD = 9.33$), ranging from 12 to 55 years. The main diagnoses were anorexia nervosa (48%), eating disorder NOS (35%), and bulimia nervosa (17%). The average duration of the ED at intake was 10.46 years ($SD = 9.32$), with a range from 0.5–40 years. Sixty eight percent of the patients had been treated for their ED before application at the current center. The patients followed several treatments at the facility

Table 1. Participants (patients) characteristics.

Characteristic	Averages and percentages
Age	$M = 27.25$ years, $SD = 9.33$ Range = 12–55 years
Gender	
Female	$N = 202$ (98%)
Male	$N = 3$ (2%)
Main diagnosis	
Anorexia nervosa	$N = 98$ (48%)
Eating disorder NOS	$N = 72$ (35%)
Bulimia nervosa	$N = 34$ (17%)
Duration of eating disorder	$M = 10.46$ years, $SD = 9.32$ Range = 0.5–40 years
Had treatment before application	
Yes	$N = 140$ (68%)
No	$N = 65$ (32%)
Treatment at facility prior to survey	
Outpatient (one hour weekly consults)	$N = 149$ (73%)
Outpatient (one hour weekly consults) + Clinical Boost program	$N = 49$ (24%)
Outpatient (twice a week day treatment)	$N = 7$ (3%)

Note: Percentages are rounded to the nearest percent.

Table 2. Participants (therapists) characteristics.

Characteristic	Averages and percentages
Age	$M = 35.12$ years, $SD = 8.76$ Range = 25–61 years
Gender	
Female	$N = 26$ (100%)
Male	$N = 0$ (0%)
Highest degree of education	
Bachelor degree	$N = 19$ (74%)
Master's degree	$N = 5$ (19%)
Otherwise (Post Master)	$N = 2$ (7%)
Number of years working as a therapist	
7–30 years	$N = 4$ (16%)
5–6 years	$N = 7$ (26%)
1–4 years	$N = 15$ (57%)
Average caseload	
25 > patients	$N = 2$ (8%)
21–25 patients	$N = 5$ (19%)
16–20 patients	$N = 9$ (34%)
11–15 patients	$N = 6$ (23%)
1–10 patients	$N = 4$ (15%)
Currently have an eating disorder?	
Yes	$N = 0$ (0%)
No	$N = 26$ (100%)
Years being recovered before started working as a therapist	
< 3 years	$N = 6$ (23%)
3–5 years	$N = 6$ (23%)
6–10 years	$N = 5$ (19%)
> 10 years	$N = 9$ (35%)

Note: Percentages are rounded to the nearest percent.

Human Concern, up to administering the survey. Seventy three percent of the patients followed outpatient therapy. This involved a 1-hour consult with a recovered therapist (once/twice a week, or once every 2 weeks depending on the phase of treatment), besides possible therapy from other treatment disciplines (i.e., dietitian, psychiatrist). Twenty four percent of the patients had the same outpatient treatment, but were also treated residential for a month. The residential treatment is called the Clinical Boost Program Be-LeeF! (which is a combination of the words “experience, being, and live” in Dutch). Within this Boost program, developed for severe ED patients, an intensive treatment program for 1 month is offered in Portugal instead of The Netherlands. Directly after this inpatient program they receive outpatient day treatment (8 hours a day for 2 days a week) for a month. There are mainly recovered therapists who work within this Boost program. During and after this inpatient Boost program the family/system is invited for several treatment meetings in the Netherlands. The remaining 3% of the participants received outpatient day treatment for 8 hours, twice a week.

Regarding the therapists, 100% of the therapists were women who were recovered from an eating disorder and did no longer have an ED. They had

an average age of 35.12 years ($SD = 8.76$), with a range of 25 to 61 years. Before they started to work as a therapist, 6 (23%) therapists reported to be recovered for less than 3 years, and also 6 therapists (23%) reported to be recovered between 3 and 5 years, while 5 therapists (19%) were recovered between 6 and 10 years and 9 therapists (35%) were recovered for more than 10 years. All therapists had completed an education in counseling or psychology. The educational level of the therapists is Bachelor of Science (73%), Master of Science (19%), or other (8%). Fifty seven percent of the therapists were working as a therapist for 4 years or less, 26% were working between 5 and 6 years and 16% were working for 7 years or longer. The average caseload was 16–20 patients per therapist.

The patients' view of experiential knowledge

Of the patients, 97% indicated that recovered therapist's experiential knowledge had advantages in therapy. The most stated advantages were: the patient feels recognized and heard (related to high therapist empathy, 82%), therapy safety (relationship is based on equality and acceptance, 34%), therapist has enhanced knowledge and insight into ED (26%), therapist is accessible (authentic, open, honest, 20%), and the patient feels increased sense of hope on recovery (17%). One of the patients wrote: "The therapist is more understanding with the problems I have, which makes it easier for me to tell how I really feel. This makes the problems more visible." Another patient wrote: "I always was very ashamed for myself and with the first meeting (with a recovered therapist) I directly had the feeling that I didn't have to feel ashamed, because she already knows what's going on. I didn't feel like a crazy person or outsider."

However, 11% of the patients reported that experiential knowledge can have disadvantages in therapy. Two disadvantages emerged, namely the possibility of making a negative comparison with the therapist (2%), and getting too personal with the therapist (2%).

Overall 93% of the participants indicated that the therapy they received from a recovered therapist had a positive effect on their ED recovery. A summary of the patient's responses can be found in [Table 3](#).

The therapists' view: Advantages and disadvantages of experiential knowledge

Recovered therapists defined experiential knowledge in a variety of ways. Most importantly, they considered it a source of knowledge derived from personal experiences from having had an ED. This could be the experiences with ED characteristics and consequences, but also the experience with recovery and other aspects of life. All of the therapists (100%) pointed out

Table 3. The patient’s views on experiential knowledge.

Topic/question emergent themes	N and (%)
Does experiential knowledge (from having had an eating disorder) have advantages in therapy?	
Yes	N = 198 (97%)
No	N = 7 (3%)
What kind of advantages?	
Patient feels recognized and heard (high therapist empathy)	N = 169 (82%)
Patient feels safe (equality, acceptance)	N = 69 (34%)
Therapist has enhanced knowledge and insight in eating disorder	N = 54 (26%)
Therapist is accessible (authentic, honest, open)	N = 40 (20%)
Patient feels increased sense of hope	N = 35 (17%)
Does experiential knowledge (from having had an eating disorder) have disadvantages in therapy?	
Yes	N = 23 (11%)
No	N = 183 (89%)
What kind of disadvantages?	
Making a negative comparison with the therapist	N = 5 (2%)
Not keeping enough distance	N = 4 (2%)
Do you have the idea that the therapy has a positive effect on the recovery of your eating disorder?	
Yes	N = 199 (93%)
No	N = 8 (7%)

Note: Percentages are rounded to the nearest percent.

that experiential knowledge has advantages in therapy. Specifically, three main components emerged: 1) benefits for the treatment relationship; 2) positive changes within the patient they treat; and 3) positive aspects regarding the therapist. Regarding the benefits for the treatment relationship, the following themes were mentioned; experiential knowledge can help in establishing a powerful relationship based on cooperation and trust (46%) and the relationship is based on equality (19%). With regard to “a powerful relationship based on cooperation,” the therapist meant that the therapeutic rapport established rapidly, and provided opportunities for insightful/deep conversations. According to one therapist: “The therapeutic relationship is built relatively faster and strong, which makes the treatment more successful. It’s especially difficult to build a therapeutic trustworthy relationship with people who suffer an eating disorder. Experiential knowledge definitely makes this easier.”

The most important positive aspects of experiential knowledge which were mentioned by recovered therapists were: enhanced knowledge and insight in the ED (54%); being a positive role model (35%); and high empathy (15%). Enhanced knowledge and insight was explained by recovered therapists as being able to quickly spot things, like patterns or underlying issues within the patients, and that the therapist was able to identify and understand the patient’s status in the recovery process. Being a role model was described as being “the living example” by one of the participants. The therapists were

able to show how to deal with an ED and what recovery actually means. The therapists can also be a role model by showing their own vulnerability.

According to recovered therapists, the most important changes their patients experienced were: feeling recognized and heard (77%), diminished levels of shame (54%), increased feelings of hope (42%), increased sense of trust (38%), more openness/honesty (27%), and a stronger motivation to change (23%). One of the therapists wrote that, "Patients feel more understood, because they know I went through pretty much the same things."

Sixty five percent of the recovered therapists pointed out that *having* experiential knowledge could also have disadvantages in therapy, while 42% of them reported that *using* experiential knowledge in therapy could have disadvantages. No different themes were found between *having* and *using* experiential knowledge when specifically asked about which disadvantages. Two emerging themes were reported by participants as potential disadvantages of having/using experiential knowledge, namely *projection/identification processes* (81%) and *over involvement or over concern with the patient* (50%). *Projection/identification processes* were explained by the therapists as sticking a label on the patient based on her own experiences, and the risk of making assumptions about the patient that conformed to that label. They also pointed out that identification might cause them not to challenge the patient's pitfalls in areas in which therapists themselves might still have problems. With *over involvement or over concern*, the participants described the process of letting the patient get too close to them, or letting the therapy go on too long when termination or transfer to another therapist would have been appropriate. They indicated that sometimes they felt too committed or too responsible for the patients, and worked too hard on the therapy. A summary of the therapist's responses can be found in [Table 4](#).

The therapists' view: When, how, and why use experiential knowledge?

As part of the treatment procedure at the Human Concern Foundation, all therapists start the first meeting of the treatment by telling their own life story, before they ask the patients to tell their life story. After this, they inform the patient when it might be helpful to use this experiential knowledge in the treatment. This could be in any treatment phase. For instance, when a patient is going through a difficult phase or when a patient specifically asks for certain information, and it could have a motivating or reassuring effect. According to therapists there are several ways experiential knowledge can be utilized in therapy: sharing their own past or current feelings/experiences (self-disclosure), giving specific examples from their own lives of dealing/solving or even failing with certain challenges (self-disclosure), and giving advice and tips. In total 54% of the therapists stated that when using self-disclosure or other forms of experiential knowledge, it is

Table 4. The therapists views on experiential knowledge.

Topic/question emergent themes	N and (%)
Does experiential knowledge (from having had an eating disorder) have advantages in therapy?	
Yes	N = 26 (100%)
No	N = 0 (0%)
What kind of advantages?	
Patient feels recognized and heard	N = 20 (77%)
Therapist has enhanced knowledge and insight into eating disorders	N = 14 (54%)
Patient feels less shame	N = 14 (54%)
Treatment relationship is more powerful	N = 12 (46%)
Patient feels increased sense of hope	N = 11 (42%)
Patient feels increase sense of trust	N = 10 (38%)
Therapists can be seen as a positive role-model	N = 9 (35%)
Patient is more open and honest	N = 7 (27%)
Patient feels increased motivation	N = 6 (23%)
Treatment relationship is based on equality	N = 5 (19%)
Therapist has high empathy	N = 4 (15%)
Does <i>having</i> experiential knowledge (from having had an eating disorder) have disadvantages in therapy?	
Yes	N = 17 (65%)
No	N = 9 (35%)
Does <i>using</i> experiential knowledge (from having had an eating disorder) have disadvantages in therapy?	
Yes	N = 11 (42%)
No	N = 15 (58%)
What kind of disadvantages?	
Projection/identification	N = 21 (81%)
Too much involvement/commitment in therapy from therapist	N = 13 (50%)
Why use experiential knowledge during therapeutic sessions?	
Providing insight into the recovery process	N = 21 (81%)
Establishing a working relationship	N = 13 (50%)
Activating/motivating the patient	N = 7 (27%)
How far do you go when sharing your own experiences, what do and don't you share?	
What to share is dependent on the patient, the story of the patient and the situation during the session	N = 14 (54%)
I don't tell details about the symptoms	N = 12 (46%)
I don't mention any weights (past lowest weight or current weight)	N = 8 (31%)
I don't tell intimate personal details	N = 5 (19%)
What's important when applying your experiential knowledge in a careful manner?	
Self-insight/self-care	N = 16 (62%)
Training, guidance and support	N = 14 (54%)
Purposefully/functional	N = 8 (31%)
Safe work environment	N = 7 (27%)
Being recovered long and well enough	N = 4 (15%)
What kind of positive reactions?	
Reactions regarding recognition and understanding (tension relief, heavy nodding, crying)	N = 26 (100%)
Reactions regarding openness (making more eye contact, sharing more)	N = 8 (31%)
Reactions regarding hope (patients tell they feel more hope)	N = 5 (19%)

Note: Percentages are rounded to the nearest percent.

important to adapt it to the patient's situation or request for help. Further, it was considered important for the therapist to discern if and when to apply it. When asked what to share and not to share, the therapists stated that they did not share specific details about their past symptoms (46%), such as lowest weight or current weight (31%), and participants did not tell very intimate or personal things (19%). One of the therapists wrote: "I never tell my weight or BMI, but speak of underweight and healthy weight. I do mention that I've suffered from compulsory exercising, but do not tell in detail how this manifested itself, how long this went on and other specific things. The same applies to eating behavior."

According to the participants, the following aspects were important in utilizing experiential knowledge in a careful way: self-insight and self-care (62%); adequate training, guidance and support (54%); only apply when it has a purpose, when it can help the patient (31%); a safe work environment (27%); and being recovered long and well enough (15%). Regarding self-insight, one of the participants wrote: "Make sure that you are well recovered yourself, understand where your ED was coming from, and when certain vulnerabilities may occur again." Participants pointed out that the training provided at Human Concern Foundation to become an experiential recovered therapist, peer consultation, and supervision were all important aspects of guidance. Additionally, having a safe work environment within a facility was noted as essential. For example, recovered therapists needed to be able to discuss these matters openly and among each other therapists. They also needed it to be embedded within the multidisciplinary consultations, because much of their therapeutic work is derived from this experiential knowledge, and this influences both the therapy and themselves.

The recovered therapists stated that using experiential knowledge is a therapeutic intervention which influences therapy and is used to reach specific goals within therapy. The most important therapeutic goals were; providing insight into the recovery process (81%), connecting with the patient (50%), activating/motivating the patient (27%). Participants identified a variety of things concerning the theme "providing insight in the recovery process." These included: giving examples of personal experience to show how recovery works, providing tips and advice, showing what works and what might need a change. The theme "connecting with the patient" involved showing empathy, providing trust and understanding, diminishing shame, and increasing openness by sharing personal experiences.

When asked whether there is a difference between knowledge from experiential knowledge and knowledge from education and books, all therapists stated that there is a difference. Such differences included that experiential knowledge has been lived and felt through your whole being, it is easier to use, it is knowledge from the heart, it is your own knowledge, it is remembered better, it is more extensive knowledge. Whereas educational knowledge

was described as more cognitive, more difficult to employ, mostly rational, emanating from outside oneself, and is more easily forgotten.

The therapists' view: How do patients react to experiential knowledge?

All recovered therapists reported positive reactions from patients when applying experiential knowledge. These were reactions regarding recognition and understanding (100%), patients becoming more open (31%), and reactions regarding hope (19%). Regarding the *recognition* theme, patient's indicated this by heavy nodding to show the therapist that they felt understood, crying when the therapist told her own story, showing relief of tension when they sat in the chair, or verbalizing or writing the therapist that they felt really understood or acknowledged by a clinician (sometimes for the first time). Reactions concerning *openness* included making more eye-contact, starting to share more of their own issues, and starting to ask more questions. Regarding *hope*, patients told the recovered therapists that they felt hopeful again, felt not as shameful as before, were less scared to share information, and often felt relieved because they were no longer the "only one." One of the therapists stated; "As soon as you start sharing your own personal story, patients start crying which indicates they feel recognized and understood."

Thirty-five percent of the therapists pointed out they had experienced negative reactions from patients concerning the application of experiential knowledge. There were no themes that emerged four or more times. Two therapists experienced that some patients didn't feel understood because they felt that they had a much more severe eating disorder than the therapist. Another theme was that the patient did not feel enough distance in the relationship, the therapist didn't connect in her story with the patient's story, and one therapist felt that patients were sometimes primarily looking for differences between the story of the therapist and their own story.

Discussion

Results from this study support earlier research about the advantages and disadvantages of working with recovered therapists (Barbarich, 2002; Costin & Johnson, 2002; Johnston et al., 2005; Warren et al., 2013). More specifically, results from this study indicated that the therapy process can benefit from recovered therapists who use their experiential knowledge in a timely and skillful manner. This finding was endorsed by both recovered therapists and their patients. The most important finding in this study was that the use of experiential knowledge by recovered therapists about their ED was considered a therapeutic intervention with specific therapeutic goals. These goals included providing insight in the recovery process, enhancing the working relationship, and enhancing motivation for treatment or recovery. The

recovered therapists in this study indicated that not everything is to be revealed to patients when self-disclosing information about their ED history. Critically, the therapist has to be constantly aware of the “*who, when, how and why*,” to use deliberate forms of self-disclosure. Furthermore, findings indicated that being too detailed about former symptoms (such as current or past weights), and sharing very intimate details should be avoided. These results correspond with those reported by Bloomgarden and colleagues (2003).

Findings from this study further confirm earlier studies indicating that therapist self-insight, regular self-care, a safe work environment, and supervision, training, and support are all necessary aspects when working with recovered therapists (Barbarich, 2002; Costin & Johnson, 2002; Warren et al., 2013). While perspectives from the therapists in this study correspond with previous reports that therapists should be fully recovered from their ED before entering the clinical domain (Costin & Johnson, 2002), the ED field still critically lacks consensus on the definition of recovery (Maine, McGilley, & Bunnell, 2010; Noordenbos, 2011). Additionally, our results suggested that experiential knowledge is most effectively used in an intuitive and empathic way. In other words, therapists must be keenly aware of how their own recovery process and issues have impact on their work with patients (experiential knowledge), as well as how the status of the patient’s recovery process informs their readiness and openness to experiential knowledge. Shadley and Harvey (2013) state that it is the manner in which recovered therapists congruently use themselves that truly provides the therapeutic skills. They propose that training programs and supervisory situations should provide therapists with opportunities to effectively interweave their personal history and identity with a congruent and deliberate professional use-of-self style (Shadley & Harvey, 2013). An important goal and part of the training to become an professional recovered therapist at Human Concern is to learn this in an effective and congruent manner (Netten, 2003).

This study has several limitations, which should be kept in mind. First, the sample was taken from one specialized ED treatment center in The Netherlands which works with experienced recovered therapists. Therefore these results may not be generalized to all recovered providers who treat patients with EDs in other treatment centers. The therapists in this study were specifically hired because of their recovered status. They were also trained on how to use their experiential knowledge in the therapy process, and the center actively works on creating a corporate culture that supports recovered therapists in their work.

Second, this study did not inquire about other therapist factors, such as the therapist’s illness, which could have impacted the treatment process (e.g., duration of illness, length of recovery, history of therapy). Moreover, this study did not look at differences in the professional education level of the

therapist. Third, this study used a qualitative cross-sectional design instead of a randomized controlled study. Therefore no statements about causality can be made.

The results of this study might have important implications for clinical practice and future research. It is advised to establish guidelines in the ED field about working with recovered therapists and how to effectively utilize the experiential knowledge they can bring into therapy. Further research is needed to elaborate on the process and outcome of utilizing this experiential knowledge by recovered therapists in the treatment process. A more quantitative, experimental study design is further advised. Lastly, consensus within the ED field on the definition of recovery will be essential to extrapolate meaningful and relevant recommendations from future research on this topic.

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